for January, 1873, page 277, which, with the one noted below, we have the excellent authority of Surgeon Otis (*Medical and Surgical History of the War of the Rebellion*, Surgical Volume, 2d Part) for saying constitute all the reported cases up to the date of his writing (1873).

Dr. CHAS. L. STODDARD, of East Troy, Wis., reports (*Med. and Surg. Reporter*, 1861, vol. vii. p. 126) the case of a man, aged 58 years, from whom the kidney was extirpated on account of encephaloid disease, the operation having been undertaken in the belief that the mass was a cystic tumour of the liver, and its true nature was not discovered until after the operation was performed. The patient survived fifteen days, and died from exhaustion believed to be due to the extensive suppuration which followed the operation.

43. *Billroth's Case of Extirpation of the Larynx and Epiglottis; Artificial Vocal Diseases.*—In our preceding number, p. 556, we gave an account of this remarkable operation, and now add a report of the subsequent history of the case as communicated to the *Irish Hospital Gazette* (May 1), by Dr. CARL SCHWAIGHOFER.

The wound healed rapidly, and what after the operation was four inches long, had soon contracted so much as to necessitate the use of the knife to allow of the insertion of a medium-sized canula. In like manner the cavity formed by the removal of the larynx contracted so much that its sides were only kept from contact by the apparatus which was inserted. The effect of the contraction of the cicatrix on the trachea was to draw it powerfully upwards, and thus the wound made in the œsophagus by the operation was considerably lessened. The apparatus invented by Billroth's assistant, Dr. Gussenbauer, consisted of three parts—1. An ordinary Trendelenburg's canula, of large calibre and good length, and having a large oval aperture at the point of greatest convexity. This canula was inserted into the trachea, and fastened in its place in the usual way. 2. A second canula with the same curvature, and just so much smaller as to fit accurately within the first. This also had a large corresponding oval opening. This canula was inserted into the former, but in a contrary direction; that is to say, its inner end, instead of pointing, as that of the first did, towards the trachea, pointed towards the pharynx. In these positions the two oval openings corresponded, and the passage for the air from the trachea to the mouth was free, and the patient could, by closing the opening, breathe through his mouth. That part of the apparatus which was intended to produce the voice, consisted of a short, straight canula, open at one end, closed at the other. In its walls, and exactly opposite each other, were two openings. Further, it was divided down the centre by a partition, in which was inserted the metal tongue which, by its vibrations, produced the voice sounds. This latter canula was inserted into the second, and fixed by means of a sliding-ring. When the three canulæ were in position the openings corresponded; and when the patient closed the outer opening the air was compelled to pass through the third canula, and in so doing to cause the metal tongue to vibrate and thus produce sounds. The patient is, however, able to inspire through the lower opening without causing the metal tongue to vibrate sufficiently to produce a sound. By means of this apparatus the patient can make himself understood in a large room, although, as would be expected, the tone of his voice, though not to say unpleasant, is rather monotonous. He has no difficulty in taking solid food, and it is only when he tries to swallow fluids rapidly, that a drop sometimes falls into the canula; which is, however, easily again cleared by the patient coughing. The man has recovered his former healthy and robust appearance, and as no attempt has been made at the formation of further new growth up to the beginning of March, the man was then discharged from the Hospital, and has returned to his former occupation a living and happy triumph of modern surgery, and, more especially, of the skill and daring of Professor Billroth.

44. *Resections of the knee.*—According to M. CHERRU the following are the statistics of all the resections of the knee in the French Army during the Franco-Prussian war, and the war of the Commune (1870, 1871). Of 65

partial resections of the knee involving only the condyles of the femur, there were 62 deaths. Of 37 complete resections, involving both femur and tibia, there were 33 deaths and 4 cures. The resection of the knee then was followed by less favourable results than amputation of the lower part of the femur.

M. Penière states in his thesis that of 20 resections of the knee there were 17 deaths; but 4 resections made in Paris during the siege must be added. According to M. Le Fort, of these last four cases three were cured.—*Gazette Hebdom.*, April 17, 1874.

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45. *Tibio-Calcanean Osteo-Plastic Operation.*—M. J. Le Fort describes the following operation as an improvement of Pirogoff's osteo-plastic method. He commences the incision 2 centimètres (.8 inch) below the malleolus externus, and directs it forwards to the middle third of the os calcis. On arriving at this point, the knife describes a curve whose anterior convexity corresponds with the astragalo-scaphoid articulation; as soon as the internal ligaments of the foot are reached, the knife is directed backwards, and stopped at a point 3 centimètres (1.2 inch) in front of the inner malleolus. Then lifting up the foot, he fashions a plantar flap equally convex with the dorsal, passing transversely under the sole of the foot, and meeting the external incision below the outer malleolus. Next, the dorsal flap is dissected up, in order to find the tibio-dorsal articulation, and great care is taken in isolating the flap so as not to wound the posterior tibial vessels. Dividing the ligaments attaching the foot to the fibula, the point of the knife is thrust between the os-calcis and the astragalus, as in the subastragaloid amputation, and the interosseous ligaments are divided. The foot is then separated and dislocated inwards, and the posterior flap fashioned as in Chopart's amputation. In order to disengage the astragalus, it is seized with a strong pair of forceps, and all attachments to the leg are divided. It only remains then to saw the os calcis from behind forward, from which the whole superior articular surface is removed, in such a way as to extend forward close to the articulating surface with the cuboid. Afterwards, all the soft parts being isolated, the articular surface of the tibia and fibula are sawn off, and the cut surfaces of the bones placed in apposition. M. Le Fort maintains that by this method he obtains a firm and perfect basis of support, without the grave inconveniences attending Pirogoff's method.—*Lond. Med. Rec.*, March 25th, from *Gazette Hebdomadaire*, Nov. 7, 1873.

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46. *Fractures of the Skull with Reference to Operative Interference.*—Dr. Corley, Surgeon to Jervis Street Hospital, relates (*Dublin Journ. Med. Sci.*, April, 1874) five cases of fractures of the skull to illustrate the statement of Mr. J. Hutchinson that depression of bone is rarely the cause of symptoms of compression, and defines the cases in which he considers trephining should be avoided and when necessary.

1. *Simple fissure.*—For this fracture the operation should never be performed. True, that accompanying the injury there *might* be localized extravasation of blood; or, subsequent to and consequent on it, there might be formation of matter, which may require the application of the trephine, but the operation then has no reference to the fracture.

2. *Simple comminuted fracture.*—A fracture may be simple externally, but the inner table may be more extensively fractured, and fragments may wound the dura mater or brain. This condition cannot be guessed at until symptoms of intra-cranial mischief arise—for them, and not for the fracture, we may trephine.

3. *Depressed fracture.*—I do not make any distinction between simple depressed and compound fracture as to operative treatment. The latter is more liable to be followed by intra-cranial mischief. As long as no symptoms are present, or *if present, until we have tried all other means of removing them*, we should not operate. If obliged to interfere we do so with little hope, as the symptoms are most likely to own an origin other than the depressed bone.

4. *Depressed fracture comminuted*—including that which is known as "punctured" fracture, such as may be produced by the stab of a pointed weapon, kick